

**Authorization Of
Release/Request of Information**

Location of protective health information.

Name of Entity: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Service: _____

SS#: _____ **ID#:** _____

Name: _____

Address: _____

Ph: _____ **Birthdate:** _____

Sex: _____ **Race:** _____ **Marital Status:** _____

I hereby authorize the release of the following health information only to:

Name of Entity: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Covering the period of health care from (date) _____ to (date) _____.

The purpose of this request or disclosure is _____.

This authorization shall be limited to health information pertaining to the following: (check if applicable)

<input type="checkbox"/>	Breast & Cervical	<input type="checkbox"/>	Financial Records	<input type="checkbox"/>	Maternity/Prenatal
<input type="checkbox"/>	Child Health	<input type="checkbox"/>	Genetics	<input type="checkbox"/>	Medical History*
<input type="checkbox"/>	Complete Medical Record	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Medication Records
<input type="checkbox"/>	Consultation Reports*	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	Progress Notes*
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	STD (other than HIV/AIDS)
<input type="checkbox"/>	Early Intervention	<input type="checkbox"/>	Laboratory Test	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Family Planning	<input type="checkbox"/>		<input type="checkbox"/>	
*Identify Program by Name:			For CMP Use:		

I understand that I may revoke this authorization at any time except to the extent that action has been taken thereon.
I further understand that this authorization will expire in 90 days from the date below. For Early Interventions records only, this authorization will expire in 6 months from the date below.

Patient or Representative's Signature (If patient's representative signs, please identify authority to act for the patient.)

Signature of Health Department Representative

Confidentiality Note: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulations prohibit you from making further disclosures other than treatment, payment or health care operations, without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR, Part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned or as otherwise permitted by such regulations. For Early Intervention records, all provisions of the Family Educational Rights and Privacy Act (34 CFR, Part 99) and federal regulations pertaining to Early Intervention apply.

MDH use only

PHI request sent - Date: _____ Initials: _____

PHI released from Health Department - Date: _____ Initials: _____